STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295081	A. BUILDING _____ B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVADA STATE VETERANS HOME - BOULDER CITY	100 VETERANS MEMORIAL DR BOULDER CITY, NV 89005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 11/18/08 - 11/21/08. The census at the time of the survey was 165. The sample size was 25, including 3 closed records. There were no complaints investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following findings were identified:	F 000		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure restraints used as enablers were assessed, care planned and ordered by a physician for 1 of 25 sample residents. Findings include: On 11/18/08 and 11/19/08, Resident #3 was observed transferring in the hallways throughout the day in his motorized wheelchair. The resident	F 221		1/6/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 was observed with a Velcro strap wrapped around his legs and the wheel chair. On the afternoon of 11/19/08, the unit nurse manager indicated that the Velcro strap was used to secure Resident #3's feet on the foot rests of the wheelchair. She further indicated that Resident #3 had multiple sclerosis and had no voluntary movement of his lower legs. When asked if there was a physician order or assessment and care plan for the Velcro strap, the nurse manager could not find documented evidence in the residents medical record. The admission records revealed Resident #3 was admitted to the facility on 2/7/07, with a diagnoses of Multiple Sclerosis, debility NOS, and paraplegia NOS. No documentation was in the medical record of: a) A physicians order for the Velcro restraint to secure the resident while in the wheelchair; and b) A care plan or assessments for the risks associated with the use of the Velcro strap as an enabler.	F 221		